Personal and Family Health History

File #:_____

About You:

Name:_____ Today's Date:_____

Date of Birth: _____ Age: _____ Sex: _____ Height:_____ Weight:_____

Physician's Name: ______ Physician's Phone #: _____

Who May we Thank for Referring You? _____

Home Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-Mail Address: _____

Occupation: _____ Employer: _____

Marital Status: Married Single Widowed Divorced Separated

☐ **I give RFC permission to send messages to me via email and/or text as a means of communication.**

About Your Family:

Spouse's Name: _____ Spouse's Occupation: _____

How Many Children Do You Have? _____

	Patient	**Spouse**	**Child #1**	**Child#2**	**Child#3**
Circle All that Apply					
1. Was Your Birth Traumatic?	Y	Y	Y	Y	Y
2. Have You Fallen as a Child?	Y	Y	Y	Y	Y
3. Have You Fallen as an Adult?	Y	Y	Y	Y	Y
4. Have You Had a Car Accident?	Y	Y	Y	Y	Y
5. Have You Played Sports?	Y	Y	Y	Y	Y
6. Are You Stressed Out?	Y	Y	Y	Y	Y

What Brings You to Our Office?

Describe Your Symptoms: _____

_____

Date When Symptoms First Appeared: _____

Did it Begin: (circle) *Gradually* *Suddenly* *Progressed over Time*

Was this Problem Due to an Auto Accident or Work Related Injury? (circle) *Yes / No*

What Makes the Symptoms Worse? _____

Quality of Pain: (circle) *Dull/Achy* *Sharp/Stabbing* *Burning* *Throbbing* *Electrical*

Does the Pain Radiate into Your: (circle) *Arm* *Leg* *Head* *Does Not Radiate*

Do You Experience Numbness or Tingling? (circle) *Yes / No*

What Percent of the Time Do You Experience these Symptoms? *100%* *75%* *50%* *25%* *10%*

What Have You Already Tried to Resolve this Problem: (check ALL that apply)

☐ Over the Counter Drugs ☐ Prescription Drugs ☐ Physical Therapy ☐Surgery

☐ Chiropractic ☐ Massage Therapy ☐Acupuncture ☐ Nutritional Supplements

Patient Signature: _____ Date: _____

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File #: _____

Medical History:

Check ANY of the Symptoms YOU have Noticed (◘ = Previously, ☐ = Now)

◘ ☐ Low Back pain/ Stiffness	◘ ☐ Auto Accidents	◘ ☐ Vision / Eye Problems	◘ ☐ Sports injuries
◘ ☐ Mid Back Pain /Stiffness	◘ ☐ Hi/Lo Blood Pressure	◘ ☐ Ear problems	◘ ☐ Frequent Colds / Flu's
◘ ☐ Upper Back Pain/Stiff	◘ ☐ Work injuries	◘ ☐ Nose / Sinus Problems	◘ ☐ Prostate Problems
◘ ☐ Neck Pain/Stiffness	◘ ☐ Other Accidents/Falls	◘ ☐ Throat Problems	◘ ☐ Female Problems / PMS
◘ ☐ Headaches	◘ ☐ Fractured Bones	◘ ☐ Thyroid Problems	◘ ☐ Incontinence
◘ ☐ Migraine	◘ ☐ Sore Achy Muscles	◘ ☐ Allergies	◘ ☐ Impotence
◘ ☐ Pain Radiating into Arm	◘ ☐ Tiredness / Fatigue	◘ ☐ Respiratory Problems	◘ ☐ Pain w / Coughing
◘ ☐ Numbness/Tingling Arm	◘ ☐ Dizziness	◘ ☐ Heart Problems	◘ ☐ Pain w / Sneezing
◘ ☐ Carpal Tunnel Syndrome	◘ ☐ Fainting	◘ ☐ Circulation Problems	◘ ☐ Pain @ Stools
◘ ☐ Shoulder Pain/Stiffness	◘ ☐ Stress	◘ ☐ Digestion Problems	◘ ☐ Ulcers
◘ ☐ Elbow Pain / Stiffness	◘ ☐ Tension	◘ ☐ Intestine Problems	◘ ☐ Cancer
◘ ☐ Wrist/Hand Pain Stiff	◘ ☐ Nervousness	◘ ☐ Colorectal Problems	◘ ☐ Restricts Exercise
◘ ☐ Hip Pain or Stiffness	◘ ☐ Irritability	◘ ☐ Liver / Gall Bladder	◘ ☐ Unable to Work
◘ ☐ Pain Radiating into Leg	◘ ☐ Anxiety	◘ ☐ Kidney Problems	◘ ☐ Poor Diet
◘ ☐ Knee Pain or Stiffness	◘ ☐ Concentration	◘ ☐ Diabetes/Hypoglycemia	◘ ☐ Inadequate Water Intake
◘ ☐ Ankle/Foot Pain/Stiff	◘ ☐ Mood Disorders	◘ ☐ Bladder Problems	◘ ☐ Inadequate Exercise
◘ ☐ Trouble Walking	◘ ☐ Depression	◘ ☐ Skin Problems	◘ ☐ No Energy
◘ ☐ Restricts Daily Activity	◘ ☐ Memory Loss	◘ ☐ Excessive Sweating	◘ ☐ Other _____

Please List ALL medications you are taking: _____

_____

Please list ALL Hospitalizations and Surgeries (with dates): _____

_____

Please list ALL Traumas (Sports Injuries, Automobile Accidents, Slips & Falls): _____

_____

_____

Please List ALL known Allergies: _____

_____

Do you have any Implants, Surgical Hardware, Pacemakers or Metallic Sutures? (circle if Yes)

Are You Pregnant? ☐ Yes ☐ No Date of Start of your last menstrual Cycle: _____

Have you ever been diagnosed with: ☐ Cancer ☐ Diabetes ☐ Cardiovascular Disease ☐ Stroke

Please list ALL dietary supplements you're taking: _____

_____

How many glasses of Water (per day) do you drink? _____

How many times a week do you exercise? _____How many hours of sleep do you get per day? _____

How would you rate your diet? (circle one) Poor ← 1 2 3 4 5 → Excellent

How would rate your overall energy? (circle one) Poor ← 1 2 3 4 5 → Excellent

How would you rate your Stress Levels? (circle one) Poor ← 1 2 3 4 5 → Excellent

Upon Completion of your fist visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please Review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of Participation that supports you in reaching ALL your health goals.

As a result of my Chiropractic Care, I would like to (Please Check ALL that apply)

☐ ***Feel Better Quickly*** ☐ ***Have a healthier Spine and Nervous System*** ☐ ***Live a healthier lifestyle***

Patient Signature _____ **Date** _____

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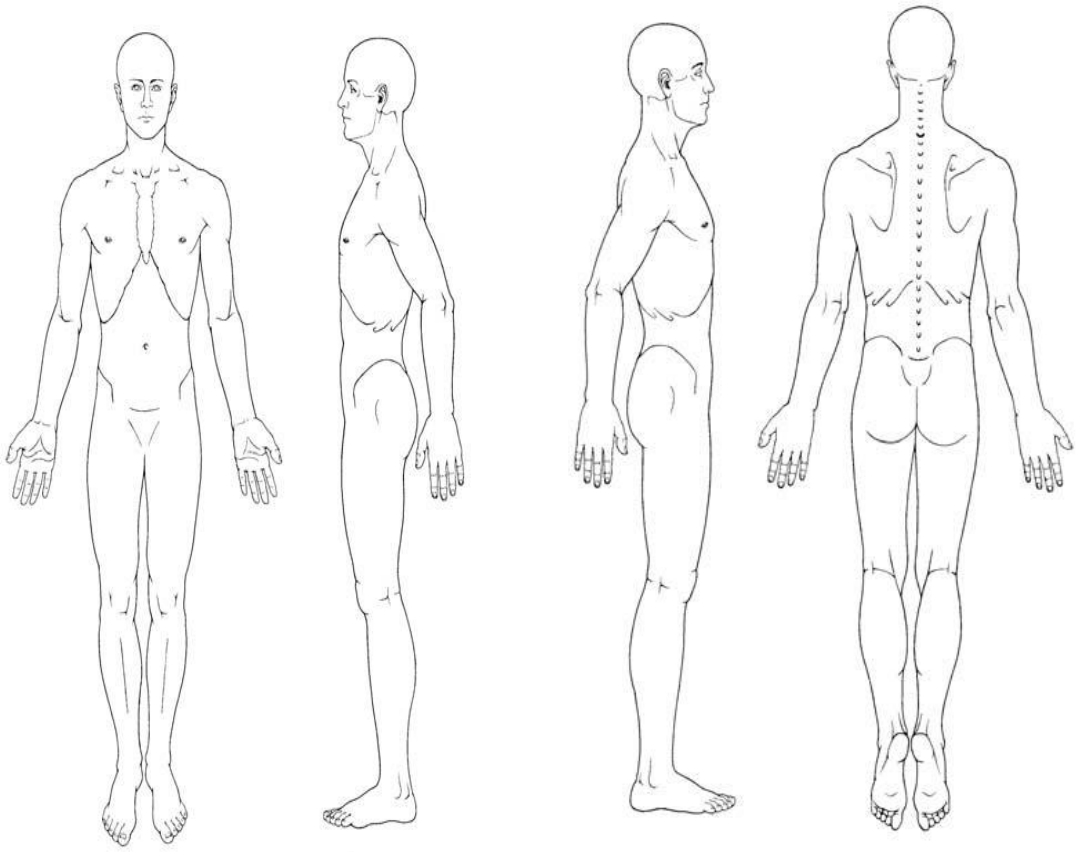
File #:_____

Location of Symptoms

Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain)

Pain = **PPP**	Tingling = **TTT**
Numbness = **NNN**	Cramping = **CCC**
Burning = **BBB**	Radiating Pain = /\/\/\/\/



Severity of Pain & Symptoms

Please Mark an "X" on the lines below to indicate the intensity of your Pain

1. Right Now: None ---------- Worst Possible
2. Average: None ---------- Worst Possible
3. At Worst: None ---------- Worst Possible

Patient Signature _____ Date _____

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PERSONAL INJURY/WORKMEN'S COMPENSATION QUESTIONAIRE

File#_____

NAME_____ Date of Accident _____ Time_____

Where did it happen? _____

Describe the Accident in your own words _____

_____

_____

What was your position in the car? ☐ Driver ☐ Passenger If passenger, were you sitting in: ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your vehicle struck by other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side ☐ from the rear?

At the time of impact, were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on the steering wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No Did you brace for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window ☐ Other _____

Please state part of body struck: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head ☐ Other _____

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a Daze? ☐ Yes ☐ No Did you go to a Hospital? ☐ Yes ☐ No

If you went to a Hospital, when? At the time of the accident? ☐ Yes ☐ No The Next Day? ☐ Yes ☐ No ☐ Other _____

How did you get to the hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the Ambulance attendants place you in: Neck collar? ☐ Yes ☐ No Splints? ☐ Yes ☐ No Brace? ☐ Yes ☐ No

Name of Hospital? _____

Attended by Doctor _____ Were you X-rayed at the Hospital? ☐ Yes ☐ No

What was the Diagnosis & X-ray Findings? _____

Were you admitted to the Hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? ☐ See your own Doctor ☐ See Orthopedic Doctor ☐ Physical Therapy ☐ Do Nothing ☐ Other _____

Have you seen any other Doctor as a result of this accident? ☐ Yes ☐ No Doctor's Name: _____

Describe your pain: ☐ Constant ☐ On and Off ☐ Sharp ☐ Dull ☐ Burning Sensation ☐ Occurs with movement ☐ Other _____

Is your pain worse when: ☐ Arising from a chair ☐ Straining ☐ Coughing ☐ Sneezing ☐ Straining when moving your bowels?

Do you have any numbness or tingling in your: ☐ arms ☐ hands ☐ fingers ☐ legs ☐ feet ☐ toes

What is your most comfortable position? ☐ Sitting ☐ Lying on your left side ☐ Lying on your right side ☐ Lying on your back

☐ Lying on your stomach ☐ Standing ☐ Bent forward ☐ Leaning to the left ☐ Leaning to the right

☐ Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve the pain? ☐ Heating Pad (Dry or Moist) ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (If you tried one) relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or Resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in: ☐ Leg ☐ Arm

Has there been any changes in your: ☐ Bowel Habits ☐ Bladder Control ☐ Ability to grip ☐ Ability to walk ☐ Muscle size

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, Give the dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Do you have PIP coverage? ☐ Yes ☐ No What Company? _____

Have you retained an Attorney ☐ Yes ☐ No If no, would you like to have a referral to an Attorney? ☐ Yes ☐ No

If yes, my attorney is:_____ _____

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File #:_____

Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cold packs, electrical muscle stimulation, therapeutic ultrasound, flexion/distraction or therapeutic exercises may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as the complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated from at one in one million to one in twenty million, and can even further be reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options (besides chiropractic) which could be considered may include the following:

- *Over- the-counter analgesics:* The risks of these medications include: irritation to the stomach, liver and kidneys as well as other side effects in a number of cases.
- *Medical care*: Typically, anti-inflammatory drugs, tranquilizers and analgesics are utilized. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization:* In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery:* In conjunction with medical care adds to the risks of adverse reaction to anesthesia, hospital acquired infections, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite predictable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: Unusual risks are many times case specific and will be explained in detail if they occur.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. By signing below, I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

PATIENT SIGNATURE_____ DATE _____H

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AUTHORIZATION AND ASSIGNMENT

I hereby authorize Reisterstown Family Chiropractic / Dr. Howard M. Lipman, D.C. to furnish my attorney(s), insurance company or any third-party payor, copies of any and all records regarding illnesses and injuries suffered by me, including, but not limited to, the injuries sustained on the date of accident identified below.

I further in exchange for the reports, irrevocably assign to you, and authorize and direct my attorney(s) &/or insurance company to pay from the proceeds of any PIP, Med Pay, recovery, settlement, judgment or insurance policy, all of your charges for health care services, equipment, supplies, conferences, depositions, court testimony as an expert witness, in any representation capacity, preparation of reports and testimony provided by you as a result of the injury or condition sustained on the date of accident. This payment will not exceed my indebtedness to Reisterstown Family Chiropractic / Dr. Howard M. Lipman.

I understand that payment for services is not contingent upon recovery and that this does not relieve me of my personal, primary obligations to pay for the services when rendered. I further understand that I will be charged a monthly service charge of 1% for all aged balances which remain outstanding after forty-five (45) days. I agree to pay all court costs and related fees, reasonable attorney's fees, and post-judgment interest at the legal rate should they be incurred in the collection of these charges.

I, individually, and/or my successors hereby waive any statute of limitations defense to the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by Reisterstown Family Chiropractic / Dr. Howard M. Lipman. as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered.

I agree to all the above terms and further, irrevocably authorize my attorney &/or Insurance company to comply with the terms above.

_____	_____
Date of Accident	Patient Signature
_____	_____
Date Signed	Patient Name (Please print)
_____	_____
Witness Signature	Patient Address

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File#: _____

Emergency Contact information:

Name: _____ Relation: _____
Phone Number: _____

Name: _____ Relation: _____
Phone Number: _____
Circle one of the following:
(Yes) I give permission to share my medical information with the above emergency contact(s).
(No) I do NOT give permission to share my medical information with the above-mentioned Emergency contact(s).

Missed Appointment Fee:

In our office your visit frequency is prescribed by Dr. Lipman. For best results we expect you to comply with your prescribed treatment program. We pre-schedule appointments for your convenience. This allows you to have the days and times during the week that work best for you. If you are scheduled and can NOT make it in, PLEASE BE CURTIOUS and call to reschedule your appointment. Missed appointments with NO call and NO show will result in a $50.00 Missed Appointment Fee.

☐ Please Check to receive text and/or email communications from our office.

The following will be used to secure payments for missed appointment fees and/or any other services received by you that are deemed a balance due to the office.
As a courtesy, we will call you and let you know we will charge the amount due by the end of that day, if we do not hear from you.

Required….
Credit Card number _____ Visa Master Card Discover
Exp. Date: _____ Security Code/ CVV: _____
Billing Zip Code: _____

I approve for the above card to be charged for balances due & if I fail to call and reschedule my appointment

Sign: _____ Date: _____
*By law we MUST protect this information, and NO one will have access to your personal CC information.